

## **DATE CASE REPORT EXPORTED**

Column            1190-1197  
Length            8  
Source of Standard   NAACCR

### **Description:**

THIS IS A REQUIRED DATA ITEM

Date the reporting facility exports the electronic abstract to a file for transmission to the central registry via diskette or other electronic medium.

The format for all dates is numeric (MMDDCCYY), with 99 for unknown day or month and 9999 for unknown year, (i.e., 1899 = year 1899, 9999 = year unknown). Standard edits check that all dates are earlier than today's date.

### ***ABSTRACT PLUS:***

This data item is generated by the computer software. DO NOT type a date in this field.

## DATE OF 1ST CONTACT

Column 416-423  
Length 8  
Source of Standard NAACCR

### **Description:**

THIS IS A REQUIRED DATA ITEM

Date of the patient's first contact with the facility for the diagnosis and/or treatment of a reportable tumor. This may be the date of an inpatient admission or an outpatient visit for a biopsy, x-ray, scan, or laboratory test. If autopsy-only, use the date of death.

When Class of Case 7 (pathology-specimen only) cases are collected, the date of specimen collection from the pathology report should be used for the Date of 1<sup>st</sup> Contact. If a pathology-specimen only case is followed by patient contact with the facility for the diagnosis and/ or treatment of the respective tumor, the Date of 1<sup>st</sup> Contact is not changed. The pathology specimen collection date remains the Date of 1<sup>st</sup> Contact.

The format for all dates is numeric (MMDDCCYY), with 99 for unknown day, month, year, or century (i.e., 1899 = year 1899, 9999 = year unknown). Standard edits check that all dates are earlier than today's date.

### ***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the date of admission/first contact with the patient.

Click OK or press ENTER.

## DATE OF 1<sup>ST</sup> COURSE OF RX--COC

Column 843-850  
Length 8  
Source of Standard COC

### **Description:**

THIS IS A REQUIRED DATA ITEM

The date on which the first cancer-directed treatment (surgery, chemo, radiation, etc.) began for the cancer being reported. It might be given in a hospital or non-hospital setting.

### **Cancer-Directed Treatment:**

Cancer-directed treatment consists of procedures directed toward cancer tissues, either of the primary tumor or metastatic site. Its purpose is to modify, control, remove, or destroy cancer tissue.

First course of treatment consists of all methods of treatment recorded in the treatment plan and given to the patient before disease progression or recurrence.

All cancer directed treatments specified in the physician(s) treatment plan are a part of the first course of treatment if they are given to the patient. A treatment plan may specify more than one modality of therapy (i.e., surgery, radiation, chemotherapy, hormone therapy, immunotherapy, or other therapy). Treatment may include a combination of concurrent or adjuvant therapies.

If the physician chooses not to treat the patient because of comorbid conditions, advanced disease, or because the accepted management of the cancer is observation until the disease progresses or the patient becomes symptomatic, the date of first course of treatment is the date the physician decided not to treat.

Code the date of **excisional biopsy** as the date therapy initiated if it is the first treatment. Code the date of a biopsy documented as incisional if further surgery reveals no residual or only microscopic residual.

If the patient refuses treatment, record the date of that decision as the date of first treatment.

If the exact date of the first treatment is unknown, code the date of admission to the hospital for inpatient or outpatient treatment.

Note: Surgical procedures coded in the data items *Scope of Regional Lymph Node Surgery* and *Surgical Procedure of Other Site* are not necessarily cancer-directed therapy.

When a patient is known to have had cancer-directed treatment, but the exact date is unknown, use an approximate date for first course of treatment.

Record 00000000 as the date of first course treatment for autopsy only cases and if there was no first course therapy (example: biopsy only or “watchful waiting”).

Record 99999999 as the date of first course of treatment when it is unknown if the patient received any treatment or when the case was identified by death certificate only.

## **DATE OF 1<sup>ST</sup> COURSE OF RX—COC (Cont'd.)**

### **Non Cancer-Directed Treatment:**

Non cancer-directed treatments are not meant to destroy, control the tumor or delay the spread of disease. They are given to prolong the patient's life, alleviate pain, make the patient comfortable or prepare the patient for cancer-directed treatments.

Examples of non cancer-directed procedures include diagnostic tests, supportive care, incisional biopsies, and exploratory procedures with or without biopsies. Supportive care/relieving symptoms include pain medication, oxygen, antibiotics administered for an associated infection, transfusions, intravenous therapy to maintain fluid or nutritional balance, laser therapy directed at relieving symptoms, and hormone therapy such as megestrol acetate to improve nutritional status.

If a biopsy is not stated to be excisional, but no residual cancer was found at a later resection, assume the biopsy was excisional.

Do not code the date of non cancer-directed treatments in this field. The date of first course of treatment refers to cancer-directed procedures only.

### **Time Periods:**

For all malignancies, except leukemia, first course of treatment includes all cancer-directed treatments planned and administered by the physician(s) during or after the first diagnosis of cancer. A treatment plan may include several types of therapy and span over a long period of time, such as a year or more.

If there is no documented treatment plan, but there is an established protocol or accepted management guidelines, consider that to be the treatment plan.

If there is no documented treatment plan, no established protocol, accepted management guidelines, and the physician advisor is unavailable for consultation, use the principle that: initial treatment must begin within 4 months of the date of initial diagnosis.

For leukemias, all remission-inducing or remission-maintaining cancer-directed treatment should be recorded as first course of treatment. These treatments often span a long period of time, such as a year or more. A patient may relapse after achieving a first remission. All therapy administered after the relapse should be coded as secondary or subsequent treatment.

Consult with the physician advisor when a treatment plan is not available or it is unclear.

Treatment failure or disease progression may prompt the physician to stop therapy before the full course has been completed. Any therapy administered after the discontinuation of the initial treatment plan should be coded as secondary or subsequent treatment.

### **Treatment for Recurrence or Progression:**

All cancer-directed therapies administered for the treatment of a recurrence or progression of disease is considered secondary or subsequent treatment and should not be coded as the date of first course of treatment.

**DATE OF 1<sup>ST</sup> COURSE OF RX—COC (Cont'd.)**

***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the date first course of treatment began.

Click OK or press ENTER.

## DATE OF DIAGNOSIS

Column	283-290
Length	8
Source of Standard	SEER/COC

### Description:

THIS IS A REQUIRED DATA ITEM

The date of initial diagnosis of this cancer by any recognized medical practitioner. This is often a clinical diagnosis and may never be confirmed histologically. Even if histologically confirmed at a later date, the diagnosis date remains the date of the first clinical diagnosis and not the date of confirmation. If medical and/or pathological review of a previous condition indicates that the patient had cancer at an earlier date than previously believed, the date of diagnosis can be backdated to reflect the new diagnosis date.

### What is a Diagnosis of Cancer?

A patient has cancer if a recognized medical practitioner says so. Often times, the medical record clearly indicates the patient has cancer by using specific terms which are synonymous with cancer. However, it is not always clearly stated. It is important to identify the earliest date of diagnosis for each cancer. When dealing with ambiguous terms regarding the diagnosis, please use the following listing of ambiguous words to determine the initial diagnosis date.

#### Terms which ARE diagnostic of cancer:

apparent(ly)  
appears to  
comparable with  
compatible with  
consistent with  
favor(s)  
malignant appearing  
most likely  
presumed  
probable  
suspect(ed)  
suspicious (for)\*\*  
typical of

#### Terms which are NOT diagnostic of cancer unless additional information is supplied:

equivocal  
possible  
potentially malignant  
questionable  
rule out  
suggests  
worrisome  
cannot be ruled out

**\*\*Exceptions:** If a cytology report indicates a specimen is “suspicious”, do not interpret it as a diagnosis of cancer. Abstract the case only if the physician’s clinical impression or a positive biopsy supports the cytology findings.

## DATE OF DIAGNOSIS (Cont'd)

### *Examples of DIAGNOSTIC terms:*

1. A mammogram report indicates a mass in the upper right breast is *suspicious for malignancy*.
2. An x-ray of the left lung indicates a mass is *consistent with carcinoma*.

### *Examples of NON DIAGNOSTIC terms:*

1. A colon mass is *worrisome for malignancy*.
2. A breast mass is *suggestive of malignancy*.

For patients diagnosed before entering the hospital (i.e., clinic or physician's office), and the date of diagnosis cannot be confirmed, use the date of first admission if it seems that the patient was hospitalized within a reasonable time (approximately 1 month or less) from the true date of diagnosis.

A patient may be diagnosed prior to surgical confirmation (i.e., diagnosed by x-ray, CT scan, etc.). Use the date of the test as the date of diagnosis.

Date of first cancer-directed therapy may be used as the date of diagnosis if cancer-directed therapy was initiated before cancer was confirmed.

If the patient receives first course of treatment and there is no information about the date of diagnosis nor is there an admission date, code the date of first treatment as the date of diagnosis.

Positive tumor markers alone are not diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

The date of diagnosis for "Autopsy Only" and "Death Certificate Only" cases is the date of death.

If the only information is "spring of," "middle of the year," or "fall," approximate these as April, July, and October, respectively. For "winter of," it is important to determine whether the beginning or end of the year is meant before approximating the month. When using these approximations for month, day should be coded unknown, "99."

In the absence of an exact date of diagnosis, make the best approximation. If there is no basis for approximation, code the date of diagnosis as unknown (99999999). If necessary, approximate the year. Approximation is preferable to coding the date unknown.

### **ABSTRACT PLUS:**

In the CURRENT VALUE box, type the date of diagnosis.

Click OK or press ENTER.

## **DATE OF LAST CONTACT**

Column            1294-1301  
Length            8  
Source of Standard SEER/COC

### **Description:**

THIS IS A REQUIRED DATA ITEM

Date of last contact with the patient or date of death. This field pertains to the patient and not to the cancer. A patient with more than one malignancy should have the same date of last contact for all records. This field can be updated with new FU information.

### **General Guidelines:**

The format for all dates is numeric (MMDDCCYY).

Use 99 for unknown day, month, year, or century.

### ***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the last date on which the patient was known to be alive or the date of death.

Click OK or press ENTER.

## **DERIVED AJCC M**

Column            665-666  
Length            2  
Source of Standard    AJCC

### **Description**

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

This is the AJCC “M” component that is derived from CS coded fields, using the CS algorithm, effective with 2004 diagnoses.

### ***ABSTRACT PLUS***

Must be derived by computer algorithm.

Press F5 to calculate collaborative staging derived fields.

## DERIVED AJCC M DESCRIPTOR

Column 667-667  
Length 1  
Source of Standard AJCC

### Description

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

This is the AJCC “M Descriptor” component that is derived from coded fields, using the CS algorithm, effective with 2004 diagnoses.

Codes	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Surgical resection performed <b>after</b> presurgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.

### *ABSTRACT PLUS*

Must be derived by computer algorithm.

Press F5 to calculate collaborative staging derived fields.

## **DERIVED AJCC N**

Column            662-663  
Length            2  
Source of Standard    AJCC

### **Description**

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

This is the AJCC “N” component that is derived from coded fields, using the CS algorithm, effective with 2004 diagnoses.

### ***ABSTRACT PLUS***

Must be derived by computer algorithm.

Press F5 to calculate collaborative staging derived fields.

## DERIVED AJCC N DESCRIPTOR

Column 664-664  
Length 1  
Source of Standard AJCC

### Description

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

This is the AJCC “N Descriptor” component that is derived from coded fields, using the CS algorithm, effective with 2004 diagnoses.

Codes	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Surgical resection performed <b>after</b> presurgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.

### *ABSTRACT PLUS*

Must be derived by computer algorithm. Press F5 to calculate collaborative staging derived fields.

## **DERIVED AJCC STAGE GROUP**

Column            668-669  
Length            2  
Source of Standard    AJCC

### **Description**

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

This is the AJCC “Stage Group” component that is derived from the CS detailed site-specific codes, using the CS from the CS algorithm effective with 2004 diagnoses.

### ***ABSTRACT PLUS***

Must be derived by computer algorithm.

Press F5 to calculate collaborative staging derived fields.

## **DERIVED AJCC T**

Column            659-660  
Length            2  
Source of Standard    AJCC

### **Description**

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

This is the AJCC “T” component that is derived from CS coded fields, using the CS algorithm, effective with 2004 diagnoses.

### ***ABSTRACT PLUS***

Must be derived by computer algorithm.

Press F5 to calculate collaborative staging derived fields.

## DERIVED AJCC T DESCRIPTOR

Column 661-661  
Length 1  
Source of Standard AJCC

### Description

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

This is the AJCC “T Descriptor” component that is derived from CS coded fields, using the CS algorithm, effective with 2004 diagnoses.

Codes	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Surgical resection performed <b>after</b> presurgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.

### *ABSTRACT PLUS*

Must be derived by computer algorithm.

Press F5 to calculate collaborative staging derived fields.

## DERIVED AJCC—FLAG

Column                672-672  
Length                1  
Source of Standard   AJCC

### Description

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

Flag to indicate whether AJCC stage was coded directly or was derived from CS or EOD codes.

Codes	Description
Blank	Not derived
1	AJCC Sixth Edition derived from <i>Collaborative Staging Manual and Coding Instructions, Version 1.0</i>
2	AJCC Sixth Edition derived from EOD (prior to 2004)

### ABSTRACT PLUS

Must be derived by computer algorithm.

Press F5 to calculate collaborative staging derived fields.

## **DERIVED SS1977**

Column            670-670  
Length            1  
Source of Standard    AJCC

### **Description**

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

This item is the derived “SEER Summary Stage 1977” from the CS algorithm (or EOD codes) effective with 2004 diagnoses.

### ***ABSTRACT PLUS***

Must be derived by computer algorithm.

Press F5 to calculate collaborative staging derived fields.

## DERIVED SS1977 FLAG

Column 673-673  
Length 1  
Source of Standard AJCC

### Description

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

Flag to indicate whether SEER Summary Stage 1977 was coded directly or was derived from CS or EOD codes.

Codes	Description
Blank	Not derived.
1	SS1977 derived from <i>Collaborative Staging Manual and Coding Instructions, Version 1.0</i> .
2	SS1977 derived from EOD (prior to 2004).

### ***ABSTRACT PLUS***

Must be derived by computer algorithm.

Press F5 to calculate collaborative staging derived fields.

## **DERIVED SS2000**

Column                671-671  
Length                1  
Source of Standard   AJCC

### **Description**

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

This item is the derived “SEER Summary Stage 2000” from the CS algorithm (or EOD codes) effective with 2004 diagnoses.

### ***ABSTRACT PLUS***

Must be derived by computer algorithm.

Press F5 to calculate collaborative staging derived fields.

## DERIVED SS2000—FLAG

Column 674-674  
Length 1  
Source of Standard AJCC

### Description

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

Flag to indicate whether SEER Summary Stage 2000 was coded directly or was derived from CS or EOD codes.

Codes	Description
Blank	Not derived
1	SS2000 derived from <i>Collaborative Staging Manual and Coding Instructions, Version 1.0</i>
2	SS2000 derived from EOD (prior to 2004)

### ***ABSTRACT PLUS***

Must be derived by computer algorithm.

Press F5 to calculate collaborative staging derived fields.

## DIAGNOSTIC CONFIRMATION

Column	311-311
Length	1
Source of Standard	SEER/COC

### Description:

THIS IS A REQUIRED DATA ITEM

Code for the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.

### Rationale:

Diagnostic confirmation is useful to calculate rates based on microscopically confirmed cancers. Full incidence calculations must also include cases that are only confirmed clinically. The percentage of cases that are only clinically diagnosed is an indication of whether case finding is including sources outside of pathology reports.

### General Guidelines:

Diagnostic Confirmation indicates how the malignancy was determined. This is a priority scheme with histologic confirmation (code 1) being the most precise and taking precedence over the other codes. Each lower number takes priority over all higher numbers.

Diagnostic confirmation must be changed to the lowest applicable code when a more definitive method confirms the diagnosis AT ANY TIME during the patient's medical history.

Code 1: Microscopic diagnoses based upon tissue specimens from biopsy, frozen section, surgery, autopsy, or D&C. Positive hematologic findings relative to leukemia, including peripheral blood smears, are also included. Bone marrow specimens (including aspiration biopsies) are coded as "1."

Code 2: Cytologic diagnoses based on microscopic examination of cells as contrasted with tissues. Included are smears from sputum, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, and urinary sediment. Cervical and vaginal smears are common examples. Also included are diagnoses based upon paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

Code 4: Diagnoses stated to be microscopically confirmed but with no detailed information on method.

Code 5: Clinical diagnosis of cancer based on certain laboratory tests or marker studies that are clinically diagnostic for cancer. Examples are the presence of alpha-fetoprotein for liver cancer and an abnormal electrophoretic spike for multiple myeloma and Waldenstrom macroglobulinemia. Although elevated PSA is non-diagnostic of cancer, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, it should be recorded as code 5.

Code 6: Visualization includes diagnosis made at surgical exploration or by use of the various endoscopes (including colposcope, mediastinoscope, and peritoneoscope). However, use only if such visualization is

## DIAGNOSTIC CONFIRMATION (Cont'd)

not supplemented by positive histology or positive cytology reports. Also use when gross autopsy findings are the only positive information.

Code 7: Cases with diagnostic radiology for which there is neither a positive histology nor a positive cytology report. "Other imaging techniques" include procedures such as ultrasound, computerized (axial) tomography (CT or CAT) scans, and magnetic resonance imaging (MRI).

Code 8: Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings.

Code 9: Cases for which it is unknown whether or not they have been microscopically confirmed. Also included are all "Death Certificate Only" cases.

Codes	Description
1	Positive histology (tissue microscopically examined).
2	Positive cytology, no positive histology (fluid cells microscopically examined).
4	Positive microscopic confirmation, method not specified.
5	Positive laboratory test/marker study.
6	Direct visualization without microscopic confirmation (Malignant mass visualized during a surgical procedure/endoscopic procedure. No microscopic examination of tissue.)
7	Radiography and other imaging techniques without microscopic confirmation.
8	Clinical diagnosis only (other than 5, 6, or 7).
9	Unknown whether or not microscopically confirmed (not statement of how the cancer was diagnosed).

### **ABSTRACT PLUS:**

In the CURRENT VALUE box, type the most accurate diagnostic confirmation code.

*or*

Select the most accurate diagnostic confirmation code from the drop-down tables.

Click OK or press ENTER.